CRIME VICTIMS COMPENSATION APPLICATION

STATE OF ILLINOIS
COURT OF CLAIMS

STATE OF ILLINOIS
ATTORNEY GENERAL

RETURN TO:

LISA MADIGAN
Attorney General
Crime Victims Department
100 West Randolph Street - 13th Floor
Chicago, IL 60601

INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION, PLEASE READ THESE INSTRUCTIONS VERY CAREFULLY
PLEASE PRINT IN BLACK INK OR TYPE

1. Please complete all sections
2. If sufficient space is not provided on this form, use additional sheets of paper as necessary.
3. If you need help completing the application, call

THE ILLINOIS ATTORNEY GENERAL'S OFFICE
CRIME VICTIMS DEPARTMENT:
312/814-2581

4. The application MUST be signed by the victim or the parent or guardian if the victim is under 18 years of age or under legal disability. In the event of the death of of a victim, the application must be signed by the survivor or a person authorized to administer the victim's estate.
5. IN THE EVENT OF THE DEATH OF A VICTIM, BE SURE TO FILL OUT SECTION 4 - DEATH BENEFITS COMPLETELY IN addition TO SECTIONS I, II, AND III.

NOTE: IF YOU CHANGE YOUR ADDRESS, YOU MUST NOTIFY THE ILLINOIS ATTORNEY GENERAL'S CRIME VICTIMS COMPENSATION PROGRAM.

YOU ONLY HAVE TWO YEARS FROM DATE OF THE CRIMINAL INCIDENT IN WHICH TO FILE THIS APPLICATION. Full verification (copies of ITEMIZED bills, completed forms, etc.) will be required prior to final processing of your claim.

I. CLAIMANT INFORMATION

Name (If other than victim) ☐ Male ☐ Female
Street Address
City/State/Zip Code Date of Birth / /
Home Telephone No. ( ) Daytime/Work Telephone No. ( )
Social Security number Relationship to Victim

VICTIM INFORMATION

Name ☐ Male ☐ Female
Street Address
City/State/Zip Code Date of Birth / / /
Home Telephone No.( ) Daytime/Work Telephone No. ( )
Social Security Number Marital Status: ☐ Single ☐ Married ☐ Divorced

PLEASE COMPLETE THE FOLLOWING, IT IS USED FOR STATISTICAL PURPOSES ONLY AND IS NEEDED TO COMPLY WITH FEDERAL REGULATIONS. PROVIDING THIS INFORMATION IS VOLUNTARY AND WILL NOT AFFECT THE DECISION OF ELIGIBILITY FOR COMPENSATION.

ETHNIC GROUP

☐ Asian or Pacific Islander (includes Indian Subcontinent origin)
☐ Black (not of Hispanic origin)
☐ White (not of Hispanic origin)
☐ Hispanic (Mexican, Puerto Rican, Cuban or other Spanish Culture)
☐ American Indian or Alaskan native

DISABILITY - Please check box if any of the following apply:

☐ For purposes of this application, a person with a disability is one who: 1) has a physical or mental impairment which substantially limits a major life activity; 2) has a record of such an impairment; 3) is perceived as having such an impairment.

II. CRIME

Police Report #_____

location of Crime _____

Street Address City/County

Date of Crime / / / / Crime Reported to _____ Date Reported / / /

(Law Enforcement Agency)

Describe the Crime: (Tell us what happened; who, what, when where) _____

_____

_____

Who committed the crime?_____Has an arrest been made: Yes No Unkn

Has the offender been charged in court: ☐ Yes ☐ No ☐ Unkn If yes, what are the charges: _____

Did the victim know the offender? ☐ Yes ☐ No ☐ Unkn If yes, in what way? _____

CRIMINAL COURT CASE # _____

III. MEDICAL

Are you claiming medical/ hospital expenses? ☐ Yes ☐ No

Are you claiming Counseling expenses? ☐ Yes ☐ No

Describe injuries:_____

_____

_____

List the name(s) and address(es) of the doctors, hospitals, counselors where victim was treated due to the injuries described above as well as any other medical expenses incurred, including mental health counseling: (Attach **itemized** copies of bills or have them sent to us)

Name	Address	Date	Amount

Will there be more medical bills? ☐ Yes ☐ No ☐ Unkn

Indicate below if any of the following sources are available to cover the related medical bills:

Source	Yes	No	Unkn	Name of Insurance Group
Private Health Plan	☐	☐	☐	
Employers/Union group Insurance Plan	☐	☐	☐	
Medicare	☐	☐	☐	
Medical Assistance	☐	☐	☐	
Public Aid	☐	☐	☐	
Worker's Compensation	☐	☐	☐	
Veterans Administration	☐	☐	☐	
Champus	☐	☐	☐	
Dram Shop Act.	☐	☐	☐	
Supplementary Security Income (SSI)/SSDI	☐	☐	☐	
Offender (Restitution)	☐	☐	☐	Amount Ordered

Is the victim covered by any other source to pay medical bills which is not listed above ☐ Yes ☐ No ☐ Unkn

If yes, indicate source

_____

IV DEATH BENEFITS

If this is a claim for death benefits, please complete the following:
A. Funeral and Burial Expenses
Are you claiming funeral expenses? ☐ Yes ☐ No Amount: $_____
Have the funeral expenses been paid? ☐ Yes ☐ No Name _____ Relationship to Victim: _____
Name of Funeral Home: _____
Address _____
Street City State Zip
PLEASE ATTACH A COPY OF THE FUNERAL BILL, BURIAL BILL AND DEATH CERTIFICATE
B. Loss of Support
At the time of death, did the victim contribute financial support for any dependent(s) ☐ Yes ☐ No
If yes, amount per month$_____

DO YOU HAVE LEGAL GUARDIANSHIP OF THE MINOR DEPENDENTS? ☐ Yes ☐ No

MINOR CHILDREN (18 YRS. OF AGE OR UNDER) OR DEPENDENTS OF VICTIM

Name	**Relationship**	**Date of Birth**
1.		/ /
2.		/ /
3.		/ /

Will the dependent(s) receive any accident or life insurance ☐ Yes ☐ No ☐ Unkn If yes, complete the following

Name of Company	Amount	Beneficiary
	$	
	$	

V. EMPLOYMENT

Are you claiming loss of earnings ☐ Yes ☐ No
Was the victim employed during the 6 months IMMEDIATELY PRIOR to the incident? ☐ Yes ☐ No
If yes, complete the following:
Name of Company _____ Occupation _____
Address _____
Street City State Zip
Telephone ( ) Net Monthly take-home wages $ _____
Did the victim miss any time form work as a result of the incident? Yes No
If yes, has the victim received any sick or disability pay? Amount $_____
Has the victim returned to work? ☐ Yes ☐ No ☐ NA Date Returned _____
Indicate below if the victim received or will receive any payment from the following sources:

Source	Yes	No	Amount per week	From (date) To (date)
Worker's Compensation	☐	☐	$	to
Unemployment Compensation	☐	☐	$	to
Private Health Plan	☐	☐	$	to
Employers Group Plan	☐	☐	$	to
Union or Fraternal Plan	☐	☐	$	to
Other, Specify	☐	☐	$	to

Did the victim have income from any of these sources?

Source	Yes	No	Unkn	Amount per month
Public Aid	☐	☐	☐	$
A.F.D.C.	☐	☐	☐	$
Social Security Disability	☐	☐	☐	$
Supplemental Security Income (SSI)	☐	☐	☐	$
Other, Specify	☐	☐	☐	$

VI. TUITION

Are you claiming tuition reimbursement? ☐ Yes ☐ No
If yes, complete the following:

Semester(s) _____ Amount _____

Name of School/College/University _____

Address _____

Telephone Number _____

VII. SUBROGATION

Please note that Sec. 17 of the Illinois Crime Victims Compensation Act states that a condition of eligibility for compensation is that each applicant must subrogate to the State his/her rights to collect damages from the assailant or any third party who may be liable in damages to the applicant.

Have you filed a civil suit against the assailant or third party? ☐ Yes ☐ No

VIII. How did you find out about the Crime Victims Compensation Program?

_____

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ ALL OF THE QUESTIONS IN THE APPLICATION AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE, ALL OF MY ANSWERS ARE TRUE, CORRECT AND COMPLETE.

I AUTHORIZE THE RELEASE OF ALL REPORTS, DOCUMENTS AND OTHER INFORMATION RELATING TO THESE MATTERS.

_____

APPLICANT'S SIGNATURE DATE SIGNED

PLEASE NOTE:
It is not required that you be represented by an attorney in order to file or process this claim. If, however, you have already engaged an attorney to assist you in filing this claim, please indicate his/her name and address below. **DO NOT LIST ATTORNEYS REPRESENTING YOU IN LEGAL MATTERS OTHER THAN YOUR CRIME VICTIMS CLAIM:**

Name of Attorney _____
Address _____
_____
Telephone _____

NOTICE TO ATTORNEYS
Under the Crime Victims Compensation Act, (Ill. Rev. Stat., 740 ILCS 45/12) counsel cannot charge a fee for presenting this form before the Court of Claims